

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext. \_\_\_\_\_ Cell \_\_\_\_\_

Would you like us to call you the evening before your next appointment?  Yes  No

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Student (School) \_\_\_\_\_ Web address \_\_\_\_\_

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- Daily or frequent headaches  Yes  No
- Daily or frequent neck pain  Yes  No
- Daily or frequent ear pain  Yes  No
- Daily or frequent facial pain  Yes  No
- Have you ever experienced an inability to open or close your mouth  Yes  No
- Have you ever been informed you have a jaw joint, bite or muscle problem  Yes  No
- When you open, does your jaw open straight  Yes  No, or it deviates  Right  Left  Both right and left
- Do you feel your bite is balanced so all teeth touch at the same time  Yes  No
- Are you aware of clenching or grinding your teeth  Yes  No
- Have you had orthodontic treatment in the past  Yes  No Teeth removed for orthodontics  Yes  No
- Have you been rendered unconscious to have teeth removed  Yes  No

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Have you had any of the following in your jaw:  Clicking  Pain  Noise on open/close  Difficulty chewing
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Please circle or complete all information that applies to your health status

## Patient Profile

### Allergic Reactions (allergy to):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Immunizations (past 10 years)

1. Tetanus
2. Polio
3. Small pox
4. Anthrax
5. Flu
6. Other \_\_\_\_\_

### Tests (within the past 5 years)

Please circle those that apply

1. Blood
2. Urine
3. Drug
4. Cardiovascular
5. HIV/AIDS
6. Cardiogram
7. Gastrointestinal X-ray
8. Gall bladder
9. MRI
10. CT scan
11. Bone Scan
12. Bone density
13. Periodontal disease
14. Temporomandibular Joint Dysfunction

### Medical / Dental Complications

(list complications) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current medications (name and dose)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Please list all significant hospitalizations

Year	Name of Hospital	Type of Illness or Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Family History (check significant diseases)

	Anemia	Bleed Easily	Cancer	Diabetes	Epilepsy	TB	High Blood Pressure	Heart	Kidney	Thyroid	Nerves	Asthma	Arthritis	Gout
Father	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Mother	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Brother	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Sister	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Children	___	___	___	___	___	___	___	___	___	___	___	___	___	___
Self	___	___	___	___	___	___	___	___	___	___	___	___	___	___

### Any other information you feel would assist us in helping you with your health care needs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal action may apply to my health care needs. I am considering or initiating legal actions against another party \_\_ Yes \_\_ No \_\_ Not sure/undecided

Name \_\_\_\_\_

Date \_\_\_\_\_

Circle numbers where you have a problem

## Review of Systems

### General

1. Health is excellent
2. Health is good
3. Health is fair
4. Health is poor

8. Palpitations (irregular heartbeat)
9. Heart medications
10. Other \_\_\_\_\_

### Dermatologic

1. Rashes
2. Dry skin
3. Bruise easily
4. Other \_\_\_\_\_

### Gastrointestinal

1. Heartburn
2. Difficult swallowing
3. Stomach pains / ulcers
4. Kidney dysfunction
5. Nausea / vomiting
6. Jaundice/ hepatitis
7. Liver trouble
8. Gallbladder
9. GI medications
10. Other \_\_\_\_\_

### Endocrine and Metabolic

1. Sugar diabetes
2. Thyroid problem
3. Cholesterol/lipid problem
4. Other \_\_\_\_\_

### Genitourinary

1. Recurrent bladder infections
2. Kidney stones
3. Prostate trouble
4. Venereal disease
5. HIV / AIDS
6. Other \_\_\_\_\_

### Hematopoietic / Lymphatic

1. Anemia
2. Lymph node enlargement
3. Bleeding problem
4. Frequent infections
5. Other \_\_\_\_\_

### Musculoskeletal

1. Joint pain
2. Joint swelling
3. Joint stiffness
4. Muscle pain
5. Muscle weakness
6. Fibromyalgia
7. Upper back pain
8. Neck pain
9. Musculoskeletal medications
10. Other \_\_\_\_\_

### Eyes

1. Change in vision
2. Glasses/contacts
3. Glaucoma
4. Other \_\_\_\_\_

### Ears

1. Infections
2. Earaches
3. Ringing / noise
4. Hearing loss
5. Dizziness/nausea
6. Other \_\_\_\_\_

### Neurologic

1. Headaches
2. Dizziness
3. Blackouts
4. Numbness/tingling
5. Paralysis
6. Convulsion/seizure
7. Other \_\_\_\_\_

### Nose and Throat

1. Sinusitis or nasal stuffiness
2. Bloody nose
3. Sore throat
4. Pain on swallowing
5. Tonsillitis
6. Other \_\_\_\_\_

### Psychiatric

1. Anxiety
2. Depression
3. Medications
4. Other \_\_\_\_\_

### Pulmonary

1. Shortness of breath
2. Emphysema
3. Asthma
4. Snoring
5. Sleep apnea
6. Other \_\_\_\_\_

### Female

1. Hormone therapy
2. Menopause
3. Other \_\_\_\_\_

### Cardiovascular

1. Chest pain
2. Heart attack
3. Heart valve
4. Rheumatic fever
5. Pacemaker
6. Congestive heart failure
7. High blood pressure

### Miscellaneous

1. Daily alcohol
2. Smoke \_\_\_ packs per day
3. Coffee or tea \_\_\_\_\_ cups/day
4. Marijuana or other drugs

# Keller Professional Group

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	
Are you under a physician's care now?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	<input type="radio"/>	<input type="radio"/>	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/>	<input type="radio"/>	_____
Are you on a special diet?	<input type="radio"/>	<input type="radio"/>	_____
Do you use tobacco?	<input type="radio"/>	<input type="radio"/>	_____
Do you use controlled substances?	<input type="radio"/>	<input type="radio"/>	_____

Women: Are you:

Pregnant / Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following (check if yes)?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? **Please check if Yes**

- |   |   |   |  |
|---|---|---|--|
| <input type="radio"/> AIDS/HIV Positive         | <input type="radio"/> Cortisone Medicine        | <input type="radio"/> Hemophilia            | <input type="radio"/> Renal Dialysis             |
| <input type="radio"/> Alzheimer's Disease       | <input type="radio"/> Diabetes                  | <input type="radio"/> Hepatitis A           | <input type="radio"/> Rheumatic Fever            |
| <input type="radio"/> Anaphylaxis               | <input type="radio"/> Drug Addiction            | <input type="radio"/> Hepatitis B or C      | <input type="radio"/> Rheumatism                 |
| <input type="radio"/> Anemia                    | <input type="radio"/> Easily Winded             | <input type="radio"/> Herpes                | <input type="radio"/> Scarlet Fever              |
| <input type="radio"/> Angina                    | <input type="radio"/> Emphysema                 | <input type="radio"/> High Blood Pressure   | <input type="radio"/> Shingles                   |
| <input type="radio"/> Arthritis/Gout            | <input type="radio"/> Epilepsy or Seizures      | <input type="radio"/> Hives or Rash         | <input type="radio"/> Sickle Cell Disease        |
| <input type="radio"/> Artificial Heart Valve    | <input type="radio"/> Excessive Bleeding        | <input type="radio"/> Hypoglycemia          | <input type="radio"/> Sinus Trouble              |
| <input type="radio"/> Artificial Joint          | <input type="radio"/> Excessive Thirst          | <input type="radio"/> Irregular Heartbeat   | <input type="radio"/> Spina Bifida               |
| <input type="radio"/> Asthma                    | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Kidney Problems       | <input type="radio"/> Stomach/intestinal Disease |
| <input type="radio"/> Blood Disease             | <input type="radio"/> Frequent Cough            | <input type="radio"/> Leukemia              | <input type="radio"/> Stroke                     |
| <input type="radio"/> Blood Transfusion         | <input type="radio"/> Frequent Diarrhea         | <input type="radio"/> Liver Disease         | <input type="radio"/> Swelling of Limbs          |
| <input type="radio"/> Breathing Problem         | <input type="radio"/> Frequent Headaches        | <input type="radio"/> Low Blood Pressure    | <input type="radio"/> Thyroid Disease            |
| <input type="radio"/> Bruise Easily             | <input type="radio"/> Genital Herpes            | <input type="radio"/> Lung Disease          | <input type="radio"/> Tonsillitis                |
| <input type="radio"/> Cancer                    | <input type="radio"/> Glaucoma                  | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tuberculosis               |
| <input type="radio"/> Chemotherapy              | <input type="radio"/> Hay Fever                 | <input type="radio"/> Pain in Jaw Joints    | <input type="radio"/> Tumors or Growths          |
| <input type="radio"/> Chest Pains               | <input type="radio"/> Heart Attack/Failure      | <input type="radio"/> Parathyroid Disease   | <input type="radio"/> Ulcers                     |
| <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Heart Murmur              | <input type="radio"/> Psychiatric Care      | <input type="radio"/> Venereal Disease           |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pace Maker          | <input type="radio"/> Radiation Treatments  | <input type="radio"/> Yellow Jaundice            |
| <input type="radio"/> Convulsions               | <input type="radio"/> Heart Trouble/Disease     | <input type="radio"/> Recent Weight Loss    |  |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

### Financial Agreement Information

The following is for:  the patient or the patient's spouse  other person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I hereby authorize payment to Keller Professional Group from my Insurance Company for services rendered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

I understand that the fee estimate listed for this dental care can only be extended until December 31<sup>st</sup> of the current year. All fees are subject to change without notice.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable collection and attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that where appropriate, credit bureau reports may be obtained.

I grant permission for my records to be used in professional publications or presentations.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_